Tribal Leaders Diabetes Committee

Meeting Summary

November 8–9, 2005

Albuquerque, New Mexico

(Approved February 16, 2006)

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Contents

TLDC Members Present:

Cathy Abramson (Bemidji Area)
Dr. Kelly Acton (Federal co-chair)
Jerry Freddie (Navajo Area)
David Garcia (Albuquerque Area)
Dr. Judy Goforth Parker (Oklahoma Area)
Deborah Hall-Thompson (Aberdeen Area)
Linda Holt (Portland Area)
Rosemary Nelson (California Area)
Roberta Nutumya (Phoenix Area)
Sandra Ortega (Tucson Area)
Buford Rolin (Tribal co-chair; Nashville Area)
H. Sally Smith (Alaska Area)

Others in Attendance:

R. Begody
Michelle Bulls
Elaine Dado
Denise Exedine
Manuel Heart
Eloisa Lucero
Dr. Kelly Moore
Diddy Nelson
Marie Osceola-Branch
Dianna Richter
Dave Toledo
Ruby Wolf
Dorinda Bradley
Althea Tortalita Cajero
Dr. Lemyra DeBruyn
Joe Finkbonner
Lois Hodge
Gale Marshall
Ben Muneta
Anthia Nickerson
J.T. Petherick
Jim Roberts
Mary Trujillo
Tammy Brown
Virginia Chama
Dr. Carolee Dodge Francis
Evangeline Gray
Kerri Lopez
Cheta Mehrotra
Robert Nakai
Marjorie Old Horn
Elise Redd
Dr. Yvette Roubideaux
Lorraine Valdez

Abbreviations:

AAGAM ..... Awarding Agency Grants Administration Manual
AI/AN ..... American Indian and Alaska Native
ADC ..... Area Diabetes Consultant
BYLD Curriculum ..... *Balancing Your Life and Diabetes Curriculum*
CCR ..... Central Contractor Registry
CDC ..... Centers for Disease Control and Prevention
CDE ..... Certified Diabetes Educator
CMO ..... Chief Medical Officer
CMS ..... Centers for Medicare and Medicaid Services
CRS ..... Clinical Reporting System
DETS Program ..... Diabetes Education in Tribal Schools Program
DDTP ..... Division of Diabetes Treatment and Prevention
DPP ..... Diabetes Prevention Program
DMS ..... Diabetes Management System
DSME ..... Diabetes Self-Management Education
DUNS ..... Data Universal Numbering System
DSTAC ..... Direct Service Tribes Advisory Committee
EHR ..... Electronic Health Record
FACA ..... Federal Advisory Committee Act
FMAP ..... Federal Medicaid Assistance Percentages
FSR ..... Financial Status Report
GPRA ..... Government Performance and Accountability Act
HIPAA ..... Health Insurance Portability and Accountability Act
IHPES ..... Indian Health Performance Evaluation System
IHS ..... Indian Health Service
IDERP ..... Integrated Diabetes Education Recognition Program
IRB ..... Institutional Review Board
ITU ..... Indian Health Service, Tribal, and urban Indian programs
MOU ..... Memorandum of Understanding
NCAI ..... National Congress of American Indians
NCUIH ..... National Council of Urban Indian Health
NEJM ..... *New England Journal of Medicine*

Abbreviations (continued):

NIDDK ..... National Institute of Diabetes and Digestive and Kidney Diseases
NIHB ..... National Indian Health Board
NPAIHB ..... Northwest Portland Area Indian Health Board
PAR ..... Performance Accountability Report
OIG ..... Office of Inspector General
OMB ..... Office of Management and Budget
RFA ..... Request for Application
RPMS ..... Resource and Patient Management System
SCHIP ..... State Children's Health Insurance Program
SDPI ..... Special Diabetes Program for Indians
TLDC ..... Tribal Leaders Diabetes Committee
TSGAC ..... Tribal Self-Governance Advisory Committee
TTAG ..... Tribal Technical Advisory Group
WIC Program ..... Women, Infants, and Children Program
WHO ..... World Health Organization

Summary of Motions:

- Motion carried to approve the TLDC meeting agenda for November 8–9, 2005 (page 8).
- Motion carried to approve TLDC charter with revisions (page 21). (See also "Summary of Action Items" for revisions).
- Motion carried to adopt the TLDC meeting summary from August 10–11, 2005 (page 22).

Summary of Action Items:

- A TLDC member requested that the TLDC consider action on expenditure reports, EpiCenter reports, and the development of a diabetes resource library (page 9).
- IHS DDTP will provide TLDC with a training and technical assistance schedule when it is finalized (page 9).
- IHS DDTP will determine if they are able to share portion of the Coordinating Center contract on the data management with the TLDC (page 11).
- IHS DDTP will share the DHHS review report at upcoming TLDC meeting (page 11).

- TLDC and IHS DDTP need to brainstorm methods to disseminate information on the chronic disease and the chronic disease strategic plan (page 17).

- TLDC recommends that meeting materials be provided prior to TLDC meetings, preferably via e-mail (page 17).

- Revisions for the TLDC charter:
    - Change "member entity" to "Area or organization" (page 18)
    - Establish a floor for the quorum (page 18).
    - Recommend to Dr. Grim that the national organizations be ad-hoc members of the TLDC (page 18).
    - Recommend procedures for when a member cannot attend full meeting (page 18).
    - Clarify whether the IHS representative is also the federal representative (page 18).
    - Establish a quorum with a simple majority of Tribal representatives (page 18).
    - Include recommendation that the primary representative contact the alternate if the primary cannot attend the meeting (page 18).
    - Change #6c to read, "If an Area/Organization does not participate…" (page 18).
    - Under #6d, change "can designate" to "shall designate" (page 18).
    - Change "will" to "shall" throughout the document (page 18).
    - Change #7 to read, "Each delegate seated at the table is allowed one vote" (page 18).
    - Incorporate language from #6d into #7 (page 18).
    - Add a provision that allows national organizations to vote in an advisory capacity on contentious issues to Dr. Grim so that he is aware of their position (page 18).
    - Change #10b to read, "Meet no less than four times" (page 18).
    - Recommend that the charter address the representatives' responsibilities in obtaining meeting materials (page 18).
    - Change vision statement to read, "Empower American Indian and Alaska Native…" (page 19).
    - End the vision statement as follows: "…and values through Tribal leadership." "Leadership" implies direction, communication, and education (page 19).
    - Revise first paragraph to reflect TLDC meeting of November 8 and 9, 2005 (page 21).
    - Obtain clarification from IHS Headquarters on how the FACA guidelines apply to TLDC membership composition (page 21).
    - Outline reasons for non-voting capacity of national organizations in the letter to Dr. Grim that accompanies the charter (page 21).
    - Change #5g to read, "…a key role of the IHS representative is to keep the director apprised…" (page 21).

- The IHS DDTP should consider developing a policy memo on the use of names and allowable costs (page 23).
- The IHS DDTP will provide the e-mail on Diachrome to TLDC members and meeting attendees (page 23).
- A TLDC representative proposed a recommendation to Dr. Grim that he should instruct Area directors to make all Tribes in the Area aware of available funding and give every Tribe an opportunity to receive funding (page 29).
- A TLDC representative requested a report from the Office of Information Technology on the status of the EHR and other data activities at the next TLDC meeting (page 29).
- The next TLDC meeting will be February 15 and 16, 2006, in Nashville (page 30).
- The TLDC recommended the following items for the next TLDC meeting agenda: (1) reauthorization of the SDPI, including the SDPI Advocacy Packet, engaging partners like the ADA and Juvenile Diabetes Research Foundation, and inviting Congressional staffers; and (2) physical activity breaks (page 30).

Tribal Leaders Diabetes Committee Meeting

Meeting Summary

Day 1: November 8, 2005

Subject	Discussion	Action
Welcome, introductions, and review of agenda Motion carried to approve the TLDC meeting agenda for November 8–9, 2005	**Day One—Tuesday, November 8, 2005** **Mr. Buford Rolin, Tribal co-chair, called the meeting to order at 8:53 a.m.** Mr. Rolin: – Welcomed TLDC members and guests and delivered the blessing. – Provided an update on Hurricane Katrina relief. – Asked TLDC members and guests to introduce themselves. – Reviewed the meeting agenda. Ms. Smith moved to approve the agenda for November 8–9, 2005. Dr. Goforth Parker seconded the motion. The motion carried to approve the TLDC meeting agenda for November 8–9, 2005.	Transcript cross-reference: Pages 8–9
Update on the SDPI Background on the SDPI Update on the non-competitive grant program	Dr. Kelly Acton, director of the IHS DDTP, provided an update on the SDPI, which included a discussion of the non-competitive grant program, competitive grant program, and other grants issues. Overall, Dr. Acton reported that the SDPI is doing well and is now in its eighth year. Background on the SDPI: • The SDPI was established in 1997 by the Balanced Budget Act. • The SDPI originally received $30 million per year, which was increased to $100 million in 2000, and to $150 million in 2004. Update on the SDPI non-competitive grant program: • The non-competitive grant program is the largest part of the overall SDPI (which also includes the competitive grant program) and focuses on the prevention and treatment of diabetes. • It receives $109 million per year (out of a total $150 million per year). The majority of these funds are distributed through grants to Tribal entities. 81% are grants to Tribes, 9% are grants to IHS entities such as service units, and the rest goes to urban programs. The urban program is funded at $7.5 million. • The SDPI currently has 335 non-competitive grants. The number of grantees changes each year. • The 2004 *Report To Congress* summarizes the non-competitive grant program.	Transcript cross-reference: Pages 9–21

SDPI summer institutes	Training and technical assistance: • During the summer of 2005, the IHS DDTP and IHS Nutrition and Dietetics Training Center organized summer institutes in Portland, Oregon, and Albuquerque, New Mexico. • The IHS DDTP and IHS Nutrition and Dietetics Training Center are using grantee feedback on the summer institutes to develop the 2006 summer institutes, which will offer meaningful, hands-on training and technical assistance opportunities for grantees. • Dr. Acton will provide the TLDC with the training schedule when it is final.	The IHS DDTP will provide TLDC with a training and technical assistance schedule when it is final
Improved communications for the SDPI	SDPI communications plan: • The IHS DDTP is working with the Hill Group to improve communication between the IHS and grantees. • Ideas include newsletters, issue briefs, e-mail listservs, updated best practices and best practice toolkits, and advocacy materials (see below). • Mr. Freddie suggested that the TLDC take action on developing a diabetes resource library and begin requiring expenditure reports and EpiCenter reports.	A TLDC member requested that the TLDC consider action on expenditure reports, EpiCenter reports, and the development of a diabetes resource library
Update on the competitive grant program	SDPI competitive grant program: • 66 grantees are in the competitive grant program. • Congress directed the competitive grant program to focus on two problems: (1) primary prevention of diabetes (i.e., preventing diabetes in people who do not have it, but are at risk); and (2) the most compelling complication of diabetes, which is cardiovascular disease. • One group of grantees is working on primary prevention of diabetes, and the other group is working on cardiovascular disease. • The first review of continuation applications took place in the summer of 2005. Four programs were found to have unacceptable applications. The IHS DDTP is working with these programs on their applications. • Because of the deployments for Hurricane Katrina relief, the IHS DDTP postponed the launch date of the program interventions from the fall of 2005 to January 1, 2006.	
Research issues and the SDPI competitive grant program	Research issues and the SDPI competitive grant program: • At the end of the five years of the competitive grant program, Congress may ask certain questions about the program such as, Did you implement an intervention, and *were you able to make a difference*? • The only way to answer a question about making a difference is to compare the program to something. However, some grantees have voiced concern about comparisons, saying it sounds like research.	

Research issues and the SDPI competitive grant program (continued)	• The competitive grant program is implementing demonstration projects to see if what was found in the DPP research study could be replicated in the real world. Dr. Acton noted that this is a very important question; some would call it research, others would call it applied or translational research, others would call it programmatic activity, and others would call is simply good care (i.e., if you have a scientific study that says you can prevent diabetes, it is good care to try to do it in a group of people who have a diabetes epidemic). • After discussing this with the Coordinating Center, IHS Headquarters, ADCs, grantees, and Tribal leaders, the IHS DDTP has decided that this portion of the evaluation will be a voluntary activity. • Dr. Acton noted that it is important to be able to accurately and confidently answer the question of making a difference because Congress will likely ask this question when it decides whether to reauthorize the SDPI. • The IHS DDTP is working with the Coordinating Center to develop a comparison group that would be a more passive activity to minimize additional work for the grantees.	
How research on the SDPI competitive grant program may relate to the non-competitive program	• Ms. Holt voiced concern that the comparison evaluation may negatively affect the non-competitive grant program. Dr. Acton responded that the mission of the Indian health system is to take care of patients and deliver quality care, not to conduct research. The IHS will need to explain carefully that they track the SDPI using public health practice models, and that comparing the non-competitive and competitive SDPI programs is an apples to oranges and inappropriate comparison. Ms. Holt also noted that such a comparison may hurt the smaller Tribes. • Ms. Nutumya raised concern about use of old Tribal data by states, and how improved diabetes data systems revealed a larger diabetes problem than had originally been suspected. Dr. Acton responded that the IHS DDTP can provide 2004 diabetes data.	
Use of the term "research"	• Mr. Roberts noted that the Indian health system may limit itself if it does not use the term "research" for its evaluation activities and that it would be well served to use the terms Congress uses and supports. Dr. Acton said that this was a valid point, and that the term used most often for the Indian health system is "public health evaluation".	
SDPI data ownership and data sharing agreements	SDPI data ownership and data sharing agreements: • The SDPI competitive grant program Coordinating Center at the University of Colorado is under contract with the IHS DDTP. They cannot release or use data without permission from the IHS DDTP, who will first obtain permission from the TLDC and participating Tribes. • At the end of the program, the IHS DDTP will prepare a report to Congress that, like the non-competitive program *Report to Congress*, summarizes the program as a whole (and not individual Tribes). All data will be returned to the IHS DDTP from the Coordinating Center.	

	• At the request of Ms. Holt, the IHS DDTP will determine if they can share the data agreement section of the Coordinating Center contract with the TLDC.	The IHS DDTP will determine if they are able to share portion of the Coordinating Center contract on the data management with the TLDC
SDPI data funds	SDPI data funds: • The TLDC recommended that $5.2 million of the SDPI funds should go toward enhancing and strengthening the Indian health data system, including implementing the EHR, which the agency has been instructed to do by the Administration. • Half of the funds went to the national IHS level, and the other half went to the Areas. • The IHS has received reports from all Areas on how funds were used last year, and their plans for this year. Two Areas received less money than last year, and the funds were transferred to different service units.	
Personnel changes in the IHS DDTP	Personnel changes in the IHS DDTP: • Cheryl Wilson, former IHS DDTP administrative officer, is now the director for the IHS National Head Start Program. Lorraine Valdez is the acting administrative officer. • Dorinda Bradley joined the IHS DDTP as an SDPI project officer. She was previously with the Albuquerque Service Unit Model Diabetes Program. • The position of IHS DDTP deputy will be advertised within a month, the new deputy should begin work within another two or three months. • Dr. Frank Vinicor, former director of the CDC diabetes division, is now the deputy in charge of chronic disease at the CDC. Dr. Mike Englegau is the new director of the CDC diabetes division. • The IHS Nutrition and Dietetics Training Center is administering IHS DDTP contracts.	
DHHS review of the SDPI	DHHS review of the SDPI: • DHHS will conduct a review of the SDPI in November 2005. • DHHS reviewers will review program files, interview IHS DDTP staff and three ADCs, and visit three different grantee sites—Zuni, San Felipe, and Ramah in Navajo. • Dr. Acton will provide the DHHS report at the next TLDC meeting.	The IHS DDTP will share the DHHS review report at an upcoming TLDC meeting
SDPI Advocacy Packet	SDPI Advocacy Packet: • The TLDC needs to begin thinking about the reauthorization of the SDPI, since the program will end in 2008. • The IHS DDTP plans to develop an Advocacy Packet for the TLDC that includes one- to four-page issue briefs on specific topics related to the SDPI. • The TLDC will be asked to provide input on the content and issues	

SDPI Advocacy Packet (continued)	covered in the Advocacy Packet. Ms. Holt recommended that an issue brief should define the differences between the non-competitive and competitive grant programs, and that *both* programs are important. **Break at 10:20 a.m.**	
Update on the SDPI competitive grant program Overview of the competitive grant program Collaborative process Evaluation of the SDPI competitive grant program	**Meeting called to order at 10:30 a.m.** Dr. Yvette Roubideaux provided an update on the SDPI competitive grant program. Dr. Roubideaux is a member of the Rosebud Sioux Tribe and an American Indian physician. She is faculty at the University of Arizona, consultant for the IHS DDTP, and the co-director for the Coordinating Center for the competitive grant program. Dr. Roubideaux also provided the TLDC with information on the competitive grant program data and evaluation training. Overview of the competitive grant program: • The official titles of the programs are SDPI Diabetes Prevention Program and SDPI Healthy Heart Project. • The SDPI Diabetes Prevention Program includes 36 grantees that will implement the 16-session DPP curriculum for people with prediabetes with the hope of preventing diabetes in those individuals. • The SDPI Healthy Heart Project includes 30 grantees that will implement a clinic-based intervention to provide aggressive treatment to reduce cardiovascular disease risk in people with diabetes. • The competitive grant program has completed the last meeting of the planning year, and has started year 2 of the program. Grantees will begin starting intensive activities on January 1, 2006 (average start date) with formal recruitment of participants. • The Coordinating Center has compiled lessons learned from the first year of the program. They will work with the IHS DDTP to disseminate this information. Collaborative process: • The core elements of the program (i.e., the activities that every grantee must do as part of this program and that are important for a strong evaluation of the program) were developed through a collaborative process. • The collaborative process has been a challenge, but it is important because the IHS DDTP can say with confidence that all decisions made about this program included grantee input. Decisions are generally reached using majority opinion, not consensus. Evaluation of the competitive grant program: • Congress has required an evaluation of this program, which is critical for the reauthorization of the SDPI.	Transcript cross-reference: Pages 21–26

Evaluation of the SDPI competitive grant program (continued)	• The evaluation has been developed collaboratively with the grantees and under the direction of the IHS DDTP. Dr. Roubideaux reported that they have developed the best possible public health evaluation, given the reluctance and limitations of some programs and Tribes. • The evaluation will answer questions such as, Did the programs implement the intervention programs, what was the experience of the participants and providers, what were the challenges and barriers, and what was the result of what we did? For the short-term, did we change people's knowledge and beliefs that they can be healthier? Over the intermediate term, did we change people's behaviors and risk factors? For the long-term, were we able to change the rates of diabetes and cardiovascular disease? The grantees would also like to know the factors associated with better outcomes. The evaluation will also collect lessons learned that will help other programs. • The IHS National IRB reviewed the summary of the project, core elements, consent forms, evaluation plan, and evaluation forms, and determined that it was a public health evaluation rather than research. They decided that they did not need to provide ongoing oversight for this project. Dr. Roubideaux referred the TLDC to the IHS National IRB website for more information on the difference between public health evaluation and research.	
Coordinating Center and data issues	Coordinating Center and data issues: • The Coordinating Center provides expertise, makes recommendations, and facilitates the process. Final decisions on the program come from the IHS DDTP. • Dr. Roubideaux assured the TLDC that the Coordinating Center has systems in place to protect the data.	
Data ownership and protection	• The Coordinating Center has recommended that grantee staff sign confidentiality agreements. Local data coordinators collect the data, remove identifiers, and send the anonymous data to the Coordinating Center. The Coordinating Center does not own the data. They will analyze the data and give the results to the IHS DDTP and the grantees. Dr. Roubideaux noted that the center has a responsibility to the grantees not to violate confidentiality and will keep the data only as long as they need. • The local data coordinators will keep program files in a locked cabinet; the data coordinators are the only people at their sites with access to the keys.	
Challenges with the competitive grant program	Challenges with the competitive grant program: • Staff turnover is a major challenge. It requires that the Coordinating Center provide constant orientation for new staff. The center has recorded all of the planning meetings on DVD, which they provide to new staff, and offers orientation workshops. Dr. Roubideaux reported that staff turnover is common in the Indian health system. • Another challenge is the understanding of the collaborative process.	

Discussion with TLDC members and audience	It involves the whole group giving input, listening to the input, and then making a decision. • Another challenge is the diversity of the programs and wide range of experience. • The grantees' training needs are numerous and significant. Discussion with TLDC members and audience: • Mr. Roberts from the NPAIHB raised concern about using Excel to export data. Dr. Roubideaux responded that the goal is to get all grantees to use RPMS. For grantees that cannot use RPMS, the Coordinating Center has provided paper data collection forms. She also reported that the grantees are using Excel for their recruitment registry because it is easy to use and can accept data from RPMS. • Ms. Wolf from the Zuni competitive grant program noted the need for ongoing evaluation of the SDPI.	
Update on IHS grants policy Grants.gov Where to go for Grants.gov technical assistance	Ms. Michelle Bulls from the IHS grants policy staff provided an update on IHS grants policy. In her opening comments, she noted that distinction between public health evaluation and classic research was important to recognize when developing policy for the IHS. Grants.gov: • Ms. Bulls reported that she is working closely with Grants.gov staff to develop interactive trainings on Grants.gov application processes, such as web-based trainings, live demonstrations, and satellite trainings. She is also working on methods to help grantees that may not be able to submit electronic applications. • Grants.gov will require 100% electronic submissions next year. Ms. Bulls recently sent a "Dear Tribal leader" letter to notify Tribes that electronic applications will be the preferred method for submitting applications. The Division of Grants Operations will hold four training sessions scheduled for January 9, February 9, April 10, and possibly June 2006 on online applications. • Ms. Bulls encouraged Tribes or organizations that are not able to submit applications online to contact her as soon as possible for help with submitting paper applications. • Ms. Bulls reported that the electronic application registration process can take up to 15 days to complete, and advised grantees to register as soon as possible. If you have problems with the registration process, you can contact Ms. Bulls or Karen Sheff at the IHS DDTP. Where to go for Grants.gov technical assistance: • Michelle Bulls at the Division of Grants Operations at 301.443.6528. • Karen Sheff at the IHS DDTP at 505.248.4182. • Grants.gov e-mail support center.	Transcript cross-reference: Pages 26–30

Carryover policy Incentive policy Cost-analysis of grant applications Update on funding	• Division of Grants Operations website at: www.ihs.gov/NonMedicalPrograms/gogp Carryover policy: • The carryover policy has been streamlined and clarified. • SDPI grantees are authorized to automatically carryover all unobligated balances of up to 25% without prior approval. Grantees need to report carryover on FSRs. After the 25% threshold, SDPI grantees need to obtain approval from Lois Hodge. Incentive policy: • The grants incentive policy, was published November 1, 2005, and is retroactive to October 1, 2005, to apply for all FY 2006 grants. • The dollar threshold is $30. SDPI grantees must obtain approval from Lois Hodge for incentives over $30. Cost-analysis of grant applications: • The Division of Grants Operations conducts a cost-analysis on every grant application to make sure the costs are allowable, necessary, allocable, and reasonable, and that they fit within the approved goals and objectives of the project. Ms. Lois Hodge from the Division of Grants Operations reported that funding for first quarter grantees is currently being distributed. If grantees do not receive their awards, either the grantee still needs to provide information or the CMO has not submitted his or her review of the application.	
Chronic Disease Strategic Plan Overview of chronic disease Designing a system to manage chronic disease	Dr. Acton provided an update on the IHS Chronic Disease Strategic Plan. Overview of chronic disease: • Chronic disease has replaced acute disease as the dominant health problem in the U.S. It is now the principle cause of disability and use of health services not just in the Indian health system, but also across the nation. • Chronic disease across our nation consumes 78% of health expenditures. • Dr. Acton presented information on the prevalence of chronic disease in the U.S. Medicare beneficiary population: 10.3% have heart disease, 23% have hypertension, 9% have asthma, and nearly 7% for diabetes. Hypertension and diabetes are increasing in minority populations. Approximately 63% of the U.S. Medicare beneficiary population has one or more chronic conditions, and they consume 95% of the resources. Designing a system to manage chronic disease: • The Indian health system does not really address chronic disease other than diabetes. • Other health care systems, such as Kaiser Permanente and Group	Transcript cross-reference: Pages 30–36

Chronic Care Model	Health, who manage chronic care well, have learned that there are several elements of good chronic illness care: (1) an informed, activated patient; and (2) a prepared practice team. • The Chronic Care Model, developed by Dr. Ed Wagner, outlines the necessary elements for productive interactions between informed, activated patients and the practice team. These elements are: (1) health care organization; (2) community resources (i.e., you can't operate in a vacuum without taking into account what the community wants); (3) decision support (i.e., you cannot make decisions in a vacuum and you need good patient and lab data); (4) clinical information systems (i.e., they must be available and provide a way to make sure that Dr. A knows what Dr. B is doing so that there is continuity of care); (5) delivery system redesign (i.e., everyone is working as hard as they can, but the delivery system is not designed with the customer focus in mind); and (6) self-management support (i.e., the patient needs to be an active participant; if he or she has made the decision nor to quit smoking, then we need to respect that, deal with other issues for which they have a willingness to change, and then come back to smoking cessation at a later date to see if they are now ready to change).	
The need for a positive policy environment	• The WHO Innovative Care for Chronic Conditions Framework states that a positive policy environment is critical to managing chronic disease. Dr. Acton strongly agreed with this.	
Chronic Disease Workgroup	Chronic Disease Workgroup: • In December 2004, Dr. Craig Vanderwagen under the direction of Dr. Grim convened a workgroup to address chronic disease. The workgroup included providers, data experts, and Tribal leaders. Linda Holt and H. Sally Smith represent the TLDC on the workgroup. The final report of the workgroup will be presented to Dr. Grim in late November.	
Strategic plan	• The workgroup proposed an initiative to develop and implement strategies in the Indian health system to prevent chronic illness and to provide high quality chronic care for people who already have chronic illness by: – Activating administrative, Tribal, and clinic leadership to support the redesign of how we deal with chronic disease. – Developing a collaborative to implement the Chronic Care Model and support innovation in chronic care. – Enhancing our comprehensive clinical information management system to support chronic care. – Using interventions that focus on the key risk factors and underlying causes of multiple chronic illnesses, such as obesity, tobacco use, and depression. – Supporting selected pilot projects that will implement the strategies for improving chronic illness care.	

IHS Director's three initiatives Discussion with TLDC members and audience	Dr. Acton reported that the chronic disease initiative is one of Dr. Grim's three health initiatives. Dr. Grim wants all three health initiatives—chronic disease care, health promotion and disease prevention, and behavioral health—to integrate with one another. Discussion with TLDC members and audience: • Ms. Nutumya emphasized the importance of including emotional needs in the initiative. • Ms. Mehrotra from the Zuni SDPI felt that the IHS needs to devote resources for making changes in community infrastructure to support behavior changes (e.g., playgrounds and increasing access to produce in grocery stores). • Mr. Freddie noted the need to translate and disseminate information on chronic care and Dr. Grim's other initiatives to Tribal communities. • Ms. Smith and Mr. Toledo both noted the importance of Tribal leaders in setting the example for health behavior change. • Ms. Wolf from the Zuni SDPI suggested that each community track their progress in improving chronic care management. **Break at 12:15 p.m.**	TLDC and IHS DDTP need to brainstorm methods to disseminate information on the chronic disease and the chronic disease strategic plan
Update on the development of the TLDC charter and member guidelines Review of August version of the TLDC charter TLDC discussion on the charter	**Meeting called to order at 1:50 p.m.** Mr. Rolin led the discussion on the TLDC charter and member guidelines. Update on the progress of the charter: • Mr. Petherick from the NIHB reported that charter had been submitted to Dr. Grim on August 16, 2005, but the TLDC has not yet received a response. • Mr. Petherick combined the charter and policies and procedures information into one document for simplicity. • Mr. Petherick reviewed the changes made to the charter since the August TLDC meeting: – New section #6 titled, "Membership", to discuss methods on how TLDC representatives should be named, vacancies, absences, and proxy voting. – Item #10a discusses a quorum. – Item #10c discusses how meeting materials will be sent to both TLDC representatives and alternates. TLDC discussion on and recommendations for the charter: • Ms. Smith recommended that all meeting materials be provided to TLDC representatives and alternates prior to the meetings, preferably via e-mail.	Transcript cross-reference: Pages 36–47 See also "Summary of Action Items" on page 6.

TLDC discussion on the charter (continued)	• Dr. Goforth Parker recommended changing "member entity" to "Area or organization" throughout the charter. • The TLDC discussed how a quorum will be reached in the event of multiple TLDC vacancies. The TLDC recommended that a simple majority of the IHS Areas with appointed representatives and alternates would constitute a quorum. Ms. Smith recommended that the TLDC establish a floor for the quorum. • The TLDC discussed the voting rights of the national organizations. The TLDC recommended that the national organizations be ad-hoc members to retain the integrity of the TLDC as a Tribal leaders advisory body. Mr. Rolin noted that several of the national organizations, such as the NIHB, NCUIH, and DSTAC, do not require that its members be Tribal leaders. • Ms. Nutumya voiced concern about the need for members to attend the full meeting unless excused. • Mr. Rolin recommended obtaining clarification on whether the IHS representative was intended to serve as the federal representative. • Ms. Nutumya suggested that the charter include procedures for the primary TLDC representative to contact the alternate if the primary representative is unable to attend the meeting. • The TLDC recommended changing #6c to, "If an Area/organization does not participate in a scheduled meeting on two successive meetings, the Area/Organization shall be notified by the TLDC with a request to replace the representatives with one who is able to participate regularly". • Ms. Smith recommended changing #6d from "can designate" to "shall designate", and recommended that "will" be changed to "shall" throughout the charter. • Dr. Goforth Parker and Ms. Smith recommended changing #7 to, "Each delegate seated at the table is allowed one vote", and deleting the rest of the sentence. (Use language from #6d if necessary.) The TLDC recommended voting for the 12 IHS Area representatives and the federal co-chair only. Ms. Smith recommended adding a provision to the charter that allows the national organizations to vote in an advisory capacity on contentious issues so that Dr. Grim is aware of their position. Mr. Petherick indicated that he would like to refer to the IHS consultation policy on this issue. • Ms. Smith suggested changing #10b to, " Meet no less than four times". • Ms. Nutumya expressed concern on the need for roles and responsibilities and a code of ethics. Mr. Rolin and Dr. Goforth Parker assured Ms. Nutumya that this would be developed. Dr. Goforth Parker also suggested that Ms. Nutumya and new members of the TLDC receive the TLDC self-evaluation report. • Ms. Smith suggested that the charter address the representatives'	

TLDC discussion on the charter (continued)	responsibilities in obtaining meeting materials. She further suggested that the IHS DDTP or NIHB use e-mail return receipts for confirmation that the representatives received their materials. • Ms. Nelson suggested changing the vision statement to read, "Empower American Indian and Alaska Native" rather than "Empowering…". • Mr. Freddie noted the importance of engaging the national organizations as stakeholders and speaking with one voice. • The TLDC recommended ending the vision statement as follows: "…and values through Tribal leadership." "Leadership" implies direction, communication, and education. **Break at 3:20 p.m.**	
NCAI resolution on data ownership	Mr. Roberts from the NPAIHB reported on the NCAI resolution regarding data collection: • The NCAI resolution grew out of concerns from the NPAIHB. The Northwest Tribal Epidemiology Center had experienced problems returning to data associated with a CDC-funded project to Tribes. • The NPAIHB passed a resolution, which formed the basis of the NCAI resolution. The resolutions outline six principles for Tribal ownership of health data collected through federally funded projects.	Transcript cross-reference: Pages 47–48
Update on the DETS Program Overview of the DETS Program Update on the DETS Program	Dr. Carolee Dodge Francis, who is a consultant to the DETS Program, provided an update on the program. Overview of the DETS Program: • The DETS Program originated from the TLDC. It involves partners from the NIH, CDC, IHS, and TLDC. • The DETS Program is developing three curricula for grades K–4, 5–8, and 9–12. The curricula were designed with three objectives in mind: (1) get AI/AN students interested in science; (2) reveal a career path that AI/AN students would see as possible; and (3) integrate Native science and western science. • The lessons and units that have been created for the DETS curricula are supplement lessons. For example, if a teacher were teaching a course on biology, he or she would pull out their unit on cells, and replace it with the DETS unit. Each unit is self-contained and comes with all of the books and resources necessary to teach the unit. Update on the DETS Program: • Pilot tests of the DETS curriculum are complete. The curriculum development committees have made refinements based on the pilot test results. • The program is preparing for an NIDDK external advisory committee	Transcript cross-reference: Pages 48–53

Update on the DETS Program (continued)	review to ensure that the curricula meet national standards. • The beta evaluation phase will take the curriculum outside of the eight Tribal college and university sites to sites with no prior relationship with the program and to teachers who have not had any input into the development of the curriculum. The goal of the beta evaluation is to establish how well the curriculum worked. • Dr. Dodge Francis and Dr. Moore have presented the curriculum at meetings, such as the Navajo Coordinated School Health Fall Forum. The response to the curriculum has been very positive. They are also looking for beta test sites. Dr. Dodge Francis mentioned the Seminole Tribe in Florida and Monument Valley High School as beta test sites. • All curricula will be ready for beta testing in January 2006.	
Discussion with TLDC members	Discussion with TLDC members and audience: • Ms. Nutumya asked if the DETS Program had a website where Tribes could go for more information. Dr. Dodge Francis reported that they do not have a website because they were waiting for the curricula to complete all phases of evaluation and refinement. However, she agreed that it would be helpful to develop a website with updates on the progress of the curricula and information on presentations at conferences, meetings, and other venues. • Ms. Nutumya suggested that the DETS Program work with Head Start. Dr. Dodge Francis responded that they have considered this, and many lessons for kindergarten could be adapted for Head Start. • Ms. Wolf from the Zuni SDPI asked if physical activity was incorporated into the curriculum. Dr. Dodge Francis noted that many of the lessons include physical activity and, for the older age groups, civic action and responsibility.	
Eagle Books	Dr. Lemyra DeBruyn from the Native Diabetes Wellness Program updated the TLDC on the *Eagle Books*. • The CDC will mail the *Eagle Books* to all schools in the nation that have 10% AI/AN enrollment. • Dr. DeBruyn is also working closely with the IHS DDTP to distribute the books to SDPI grantees, and with the IHS Head Start Program. • The CDC will issue a press release to accompany the mailing of the *Eagle Books*, which will acknowledge the TLDC and the IHS DDTP. **Meeting recessed at 4:25 p.m. until 8:30 a.m. on November 9, 2005**	

TLDC Meeting Summary

Day 2: November 9, 2005

Subject	Discussion	Action
Welcome	**Day Two—Wednesday, November 9, 2005** **Meeting called to order at 9:00 a.m.** • Welcome and agenda review by Buford Rolin, TLDC Tribal co-chair • Blessing by Sandra Ortega, representative from the Tucson Area	Transcript cross-reference: Page 54
Discussion on the TLDC charter and member guidelines Motion carried to approve TLDC charter with revisions	Mr. Rolin led the discussion on the TLDC charter and member guidelines: • Mr. Petherick provided a draft of the TLDC charter with revisions based on the discussion from day one of the meeting. • The TLDC recommended the following changes to the revised version of the charter: – Revise the first paragraph to reflect TLDC discussion of November 8 and 9, 2005. – Obtain clarification from the IHS Headquarters on how the FACA guidelines apply to TLDC membership composition. – Outline reasons for non-voting capacity of national organizations. (See summary of TLDC charter discussion from day one starting on pages 17–19.) – Change #5g to read, "…a key role of the IHS representative is to keep the director apprised…". Dr. Goforth Parker moved to adopt the TLDC charter with revisions. Ms. Nelson seconded the motion. The motion carried to approve the TLDC charter with revisions. Mr. Rolin noted that he and Dr. Acton will send a revised charter that incorporates the TLDC's recommendations and a cover letter to Dr. Grim.	Transcript cross-reference: Pages 54–60 (See also "Summary of Action Items" on page 6)
Update on the Nike shoe project	Ms. Gale Marshall is a consultant to the IHS DDTP. She has been working on the Nike and IHS shoe project and provided an update to the TLDC: • The goal of the project is develop footwear that is designed especially for AI/AN to help motivate people to begin and maintain walking and other activity programs. • Nike and the IHS DDTP are currently conducting consumer insight groups, which is another name for focus groups, across the country. They are also taking computerized foot scans of volunteers' feet to see if there are any unique characteristics of AI/AN feet.	Transcript cross-reference: Page 60

Subject	Discussion	Action
Update on the Nike shoe project (continued)	• Thus far, Nike and the IHS DDT have held focus groups in Warm Springs in Oregon; Crow Agency in Montana; Hollywood, Florida to visit the Seminole and Mikasuki Indians; and Phoenix for the NIHB. Nike plans to test the shoe in Alaska. • Nike will produce a summary report of the focus groups.	
Update on the Navajo Nation SDPI	Mr. Robert Nakai from the Navajo Nation SDPI provided an update on the Navajo Nation's activities for the National Diabetes Month: • The Navajo Nation issued a proclamation declaring November National and Navajo Nation Diabetes Month. • Navajo Nation Diabetes Month activities will include not only diabetes treatment and prevention activities (e.g., Thanksgiving meal for the Division of Health), but also gestational diabetes, WIC, behavioral health, and breast and cervical cancer activities through partnerships with other Navajo Nation programs. • The Navajo Nation SDPI has publicized these events in regional newspapers. Mr. Nakai reported that other Navajo Nation SDPI activities include working with schools and Head Start on physical activity and nutrition programs, with prisons on nutrition programs, and Navajo Nation employees through a break-time exercise initiative.	Transcript cross-reference: Pages 61–62
Review of TLDC meeting summary from August 10–11, 2005 Motion carried to adopt the TLDC meeting summary from August 10–11, 2005	The TLDC reviewed the transcript and summary from the TLDC meeting held August 10–11, 2005. Ms. Smith made a motion to adopt the summary of August 10–11, 2005. Ms. Nelson seconded the motion. The motion carried to adopt the TLDC meeting summary from August 10–11, 2005, with one abstention from the Phoenix Area.	Transcript cross-reference: Page 62
Diachrome	Dr. Acton reported that she sent an e-mail to the CMOs and ADCs, as well as TLDC members for whom she had e-mail addresses, to notify them about an issue with two companies who manufacture a nutritional supplement called Diachrome: • Diachrome is being promoted throughout Indian Country as diabetes prevention supplement. • The IHS DDTP reviews the scientific literature on any new product that claims to have significant results to see if there is evidence that	Transcript cross-reference: Pages 63–64

Subject	Discussion	Action
Diachrome (continued)	the product works. The IHS DDTP also reviews the scientific literature to obtain information on how the product or medication works and what the side effects are. • The majority of data on chromium are not compelling and convincing enough that the IHS DDTP would add this to the list of armamentariums for use. • Dr. Acton's e-mail on Diachrome notified recipients that the companies have been visiting clinics and Tribal leaders and have used IHS DDTP staff names and Tribal leader names without permission to promote their products. Dr. Acton noted that these are inappropriate tactics and that the IHS DDTP has asked the companies to stop using IHS DDTP and Tribal leader names (without permission) to promote their products. The IHS DDTP cannot promote any products because it is a federal agency. Ms. Wolf from the Zuni SDPI asked the IHS DDTP to develop policy on use of names and allowable costs. Dr. Acton responded that this information was outlined in her e-mail, which she will provide.	IHS DDTP should consider developing a policy memo on use of names and allowable costs IHS DDTP will provide the e-mail on Diachrome to TLDC members and meeting attendees
Update on the IHCIA Timeframe Issues with the IHCIA reauthorization Facilities construction	Mr. Rolin provided an update on the reauthorization of the IHCIA: • IHCIA reauthorization efforts started in 1998. • The current Administration has assured the national steering committee that they support the reauthorization. • The national steering committee has been working with the Administration and the Senate Indian Affairs Committee to introduce a new bill. Senator McCain introduced a bill, and the national steering committee is hopeful that a companion bill will come forward from the House. Senator McCain reported to the national steering committee that action on the bill will likely take place in March 2006. • Mr. Rolin noted the urgency with obtaining reauthorization since Senator McCain is expected to leave his position as the chair of the Senate Indian Affairs Committee next year. However, he noted that the national steering committee will not regress in any way. • Several challenges with the reauthorization include the Alaska issue, which involves the use of dental aides in Alaska; however, the American Dental Association is now supportive of the reauthorization efforts. Behavioral health concerns are also being addressed in the new bill since the Red Lake tragedy. The national steering committee also addressed the IHS DDTP's office that the ADCs should be written back into the bill. Mr. Roberts from the NPAIHB addressed a fourth area of concern on facilities construction: – The NPAIHB has been working with Senator Smith's office	Transcript cross-reference: Pages 64–66

Subject	Discussion	Action
Facilities construction	to offer an amendment to the IHCIA that would direct the agency to develop an Area allocation for facilities funding. – This amendment is written to benefit all Areas. Currently, not all Areas are able to benefit from the priority system. This provision will take a certain percentage of facility construction money and allocate it to the Areas for facilities construction. It would still be tied to the overall priority system. The money could be used for renovation, expansion, or new construction. – Mr. Roberts reviewed several of the safeguards that are included in the amendment. For example, what if only $3 million is appropriated for the priority system for facilities construction? If there is not enough money to fund the Area allocation, it wouldn't be implemented for that fiscal year. In addition, an Area could not double-dip by building a large facility and then also receiving the resources through the Area allocation. As long as that facility received money from Congress, it would not be allowed to participate in the Area allocation.	
Bingaman amendment on Medicaid	Ms. Nelson asked about the status of the Bingaman amendment: • Mr. Roberts reported that Senator Bingaman introduced several amendments that would revise Medicaid law to extend 100% FMAP for programs and referrals outside of IHS facilities, include no-cost sharing provisions for AI/AN participating in Medicaid, adjust true out of pocket expenses for the Medicare Act, and exempt AI/AN from estate recovery procedures. • The amendments were introduced in the reconciliation package, but were found to be irrelevant to the funding issues of the package and were therefore removed. • Mr. Roberts noted that Senator Bingaman will introduce a stand-alone bill with the same intent as his proposed amendments.	
Behavioral health issues	Ms. Hall-Thompson noted that the behavioral health and the dental aide issues are major concerns for her Area. **Break at 10:30 a.m.**	
Update on the IHS IDERP	**Meeting called to order at 10:55 a.m.** Ms. Tammy Brown from the IHS DDTP provided an update on the IHS IDERP.	Transcript cross-reference: Page 67–72
Background on the IHS IDERP	Background on the IHS IDERP: • Congress authorized Medicare reimbursement for diabetes education services in the Balanced Budget Act of 1997.	

Subject	Discussion	Action
Background on the IHS IDERP (continued)	• In March 2002, the IHS received approval from the CMS as an accrediting body. The IHS is the only other organization other than the ADA that can certify or recognize diabetes education programs as meeting the national standards for DSME. The national standards define quality diabetes care and are designed to be implemented in a variety of settings. The IHS criteria for each standard are as rigorous as the ADA standards. • Only programs that have this certification—either IHS or ADA certification—are able to obtain Medicare reimbursement.	
Benefits of the IHS IDERP	Benefits of the IHS IDERP: • IHS recognition is available only to IHS, Tribal, and urban Indian programs. • There is no application cost associated with applying for IHS recognition. However, meeting the national standards requires organization and resources. (The ADA application fee is $1,200.) • The IHS DDTP provides technical assistance by phone. Applicants can also request on-site technical assistance. The IHS DDTP asks the requesting organization to pay for the travel of the person providing the technical assistance. The IHS DDTP also offers trainings to teach people about diabetes, what the standards are, how to complete an application, and how to use the curriculum. • The IHS DDTP provides a lot of resources and supporting materials, including a samples and templates booklet, application checklists, reviewer checklists, and the *Balancing Your Life and Diabetes Curriculum*. The Albuquerque and Claremore service units have developed their own curricula, which they have made available to other programs. The IHS DDTP plans to increase access to the educational materials via CD-ROM and its website. (The IHS DDTP also hopes to automate the application process by making the application available on the web.) • The IHS IDERP acknowledges program quality and accommodates the differences in communities, geography, population size, medical facilities, and resources. • The IHS IDERP is the only program in the nation that integrates educational, clinical, and public health standards. The ADA covers only clinical and educational standards. • A review and evaluation of this program in 2001 found a trend toward better diabetes outcomes in the higher-level programs.	
IHS IDERP recognition levels	IHS IDERP recognition levels: • The IHS IDERP has developed three recognition levels that allow programs to develop and build their programs over time. • The first level is the developmental level.	

Subject	Discussion	Action
IHS IDERP recognition levels (continued)	• The second level is the educational level. At the second level, you can seek Medicare reimbursement. • The third level is the integrated level. This level demonstrates that the program has integrated education and clinical management of diabetes with community programs. Recognition as a level 3 program does not improve or increase Medicare reimbursement. Instead, it recognizes the program as a comprehensive program that includes all aspects of diabetes management. • If a program is considering applying for level 3 recognition in their first application, the IHS DDTP recommends they first apply for level 2 recognition. Ms. Brown noted that it is very difficult to reach level 3 with the first application.	
Current status of recognized programs and applicants	Status of recognized programs and applicants: • The IHS currently has 17 fully accredited programs. • The IHS has seven provisional programs, which means that they have met all but three or fewer standards. These programs have a six-month provisional accreditation. Three programs are currently provisional at level 2, and four programs are provisional at level 3. • The IHS has denied four applications. These programs can reapply in one year. The IHS IDERP offers technical assistance through a contractor to help the programs submit an improved application. • The IHS has one inactive application. This program received a provisional accreditation, and when their provisional paperwork became due, they were not prepared. They can reapply in another six months. • Each year, the IHS receives approximately five applications.	
Reviewer guidelines	Guidelines for reviewers: • The reviewers must be licensed health care professionals (e.g., physicians, nurses, registered dietitians, and pharmacists) who have received a certain amount of diabetes education. • The IHS DDTP has developed reviewer guidelines to help them conduct an objective assessment of the application. • Final decisions on the applications involve reaching consensus among the two reviewers—who represent different disciplines—and IHS DDTP staff. • The IHS DDTP provides the feedback and suggestions of the reviewers to the applicant.	
Challenges	Challenges: • A study by Dr. Yvette Roubideaux in 2001 on the IDERP found that programs experienced lack of administrative support, lack of staff, not enough time, and not enough space. Ms. Brown noted that	

Subject	Discussion	Action
Challenges (continued)	Tribal administration may not truly understand the commitment necessary for this program. • There is a diversity of understanding of program requirements. The IHS DDTP plans to offer workshops where programs bring in their draft applications and receive hands-on, technical assistance. The IHS DDTP also plans to expand mentorship opportunities. • Programs sometimes submit applications that talk more about their grant program instead of how their program meets the diabetes education standards. • Programs sometimes fall short of implementing some of the required activities. For example, an on-site audit might reveal that they have not completed the policy and procedure manual	
Medicaid Reimbursement codes Individual recognition	Discussion with the TLDC and audience: • Mr. Roberts from the NPAIHB and Ms. Brown discussed obtaining Medicaid reimbursement for diabetes education services. Ms. Brown noted that organizations in each state would need to work together to try to obtain legislation for Medicaid reimbursement. • Ms. Nutumya raised concern about the different codes used for reimbursement. Ms. Brown responded that programs need to know the Medicare and Medicaid, as well as private insurance, diabetes education codes. • Ms. Holt asked how Tribes without clinics could obtain reimbursement for diabetes education. Ms. Brown responded that the recognition program is currently for outpatient facilities. However, there are individual recognition programs separate from the IHS IDERP. For example, an RD could become a Medicare provider and become eligible for reimbursement for medical nutrition therapy services.	
Contact information for the IHS IDERP	Contact information for the IHS IDERP: • The phone number for the IHS IDERP is 505.248.4182 (Tammy Brown, Dorinda Bradley, or Sea Shorty). • The IHS DDTP website offers all IDERP materials, including the *BYLD Curriculum*, free of charge.	
Excerpt from Dr. Yvette Roubideaux's *NEJM* article	Dr. Acton reported that the November 3, 2005, issue of the *New England Journal of Medicine* included an article by Dr. Yvette Roubideaux called, "Beyond Red Lake: The Persistent Crisis in Indian Health Care". Dr. Acton commended Dr. Roubideaux for the article and read an excerpt: "Although the federal government has a trust responsibility to provide health care for AI/AN, the IHS is substantially underfunded and understaffed. This service was established in 1955 to provide primary care and public health service on or near Indian reservations. Although it can take credit for great	Transcript cross-reference: Pages 72–73

Subject	Discussion	Action
Excerpt from Dr. Yvette Roubideaux's *NEJM* article (continued)	improvements in health status, significant disparities in health and the quality of care persist 50 years later. Many factors contribute to these disparities, but the failure of the federal government to adequately fund the IHS with the provision of care to the 1.8 million patients it is supposed to serve means that the promises of the treaties in the 1800s have never been fulfilled. The IHS per capita health care expenditures are much lower than those of other health care systems in the U.S…. I hope at least that the tragedy at Red Lake serves as a wake up call to the federal government and health professionals about the pressing need for more resources to address the persistent crisis in health care for AI/AN". The reference for the article is: Roubideaux Y. Beyond Red Lake: The persistent crisis in Indian health care. *NEJM*. 2005 Nov 3;353(18):188–183.	
Update on GPRA and PAR Challenges with reporting requirements IHS GRPA score	Dr. Kelly Moore from the IHS DDTP provided an update on data reporting requirements. GPRA and PAR: • GRPA is a requirement that all government departments report to OMB and others who advise the President on the federal budget. • PAR is a newer reporting requirement of the Administration. • A main feature of the IHS's reports is glycemic (i.e., blood sugar) control in AI/AN patients with diabetes. Data on glycemic control is tracked on an annual basis through the diabetes audit, and are used to support the budget for all of the IHS. • PAR requires more data and information from Tribal programs and urban Indian programs. Challenges with the reporting requirements: • There are differences with how the data are collected in and how data compare between the GPRA+ and CRS system. • The IHS DDTP responds to questions about how the data are collected, sources of data, why there are differences, and what the differences are in the denominator (i.e., total population used). • Dr. Moore reported that there may be changes to the way data are collected in the diabetes audit and electronically through RPMS. This has caused concern among some Tribes and urban Indian programs. Mr. Rolin noted that the IHS rated highly among the 12 offices in the DHHS in the first round of scoring for GPRA.	Transcript cross-reference: Pages 73–75
Update on the diabetes data funds	Ms. Lorraine Valdez from the IHS DDTP provided an update on the diabetes data funds. She provided each TLDC member with a data distribution report and plan for their respective Areas.	Transcript cross-reference: Pages 75–79

Subject	Discussion	Action
Background on the diabetes data funds	Background on the diabetes data funds: • Dr. Grim, with guidance from the TLDC, set aside $5.2 million for data infrastructure improvement. Half of the funds, $2.6 million, went to the IHS Office of Information Technology for improvements at the national level. The other half was distributed to each of the IHS Areas through the IHS Office of Information Technology; the amounts for each Area were based on an assessment by the ADCs, CMOs, and Area directors. • Dr. Acton noted that the EHR is a revamping of the health care information system. Congress and the Administration have directed the IHS to implement an EHR.	
Use of data funds at the national level	Use of data funds at the national level: • The IHS Office of Information Technology used funds to strengthen the EHR and RPMS integrated case-management system, web-based diabetes reports and audits, IHPES, and the National Data Warehouse database and datamarts.	
Use of data funds at the Area level	Use of funds at the Area level: • Some Areas have used funds to acquire software patches, determine needs for local sites to be able to provide or access data and to implement software, and prepare for EHR implementation.	
EHR and small Tribes and compacting Tribes Distribution of funds to Areas Intent of data funds Funding formulas Report from Office of Information Technology	Discussion with TLDC members and audience: • Ms. Holt raised concern about data funds going to EHR development, which will have limited benefit to small Tribes and Tribes without clinics. She felt that small Tribes and compacted Tribes did not benefit from the data funds. She recommended that Dr. Grim should instruct Area directors to make all Tribes in the Area aware of available funding and give every Tribe an opportunity to receive funding. • Mr. Garcia noted that the data funds were allocated to Areas, not to Tribes. He felt that the IHS should have been clearer about this. • Mr. Roberts from the NPAIHB noted that the IHS needs to ensure that the data funds are used for the intent and directive from Representative Nethercutt's letter to the IHS. • Ms. Wolf from the Zuni SDPI raised concern about the funding formulas, specifically on how the funding formulas are developed and what data are used. Ms. Nutumya raised a similar concern for the small Tribes. • Mr. Garcia requested a report from the Office of Information Technology on the progress of the EHR and other data activities at the next TLDC meeting.	A TLDC member proposed a recommendation to Dr. Grim that he should instruct Area directors to make all Tribes in the Area aware of available funding and give every Tribe an opportunity to receive funding TLDC member requested a report from the Office of Information Technology on the status of the EHR and other data activities at the next TLDC meeting

Subject	Discussion	Action
IHS DDTP communication plan IHS DDTP website Communication plan	Ms. Valdez provided an update on the IHS DDTP communication plan. IHS DDTP website (www.ihs.gov/medicalprograms/diabetes/): • The website includes a TLDC section, which includes contact information, photos, and approved minutes since the inception of the TLDC. Ms. Valdez noted that the IHS DDTP does not post TLDC meeting minutes until they are approved by the TLDC. • The IHS DDTP plans to add more information and resources, including the TLDC self-evaluation and links to other organizations. • The website also includes links, documents, and training materials. The IHS DDTP plans to add more web-based training tools, as well as a tool that allows SDPI programs to update their program summaries and search through the SDPI Compendium. • People can order resources from the IHS DDTP website free of charge. Resources include: *Health for Native Life Magazine*, *Measuring Diabetes Care*, *Finding and Evaluating Health Resources on the Web*, *BYLD Curriculum*, and *A River Runs through Us: Inspirations of Wellness*. Communication plan: • The goal of the IHS DDTP communication plan is to improve communication with the Indian health system and other stakeholders, and to better market the activities of the SDPI. • The plan includes developing methods to help SDPI grantees share information; advocacy materials, such as issue briefs on the SDPI and TLDC; materials to support the emotional aspects of diabetes; and newsletters and listerservs to get information out efficiently.	Transcript cross-reference: Pages 79–81
Meeting wrap-up	The next TLDC meeting will be held February 15 and 16, 2006, in Nashville. The TLDC recommended the following items for the agenda: • Reauthorization of the SDPI: – SDPI advocacy materials. – Engaging partners like the ADA and Juvenile Diabetes Research Foundation. – Inviting Congressional staffers from committees of jurisdiction on the reauthorization for their input and suggestions and to educate them on the SDPI. • Physical activity breaks Dr. Goforth Parker thanked the audience for their input. **Meeting adjourned at 12:50 p.m.**	Transcript cross-reference: Pages 81–82 Next TLDC meeting will be held February 15 and 16, 2006, in Nashville